UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

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UNITED STATES OF AMERICA ex rel. CECILIA GUARDIOLA, Plaintiff, vs. RENOWN HEALTH, RENOWN REGIONAL MEDICAL CENTER, and RENOWN SOUTH MEADOWS MEDICAL CENTER, Defendants.	3:12-cv-00295-LRH-VPC ORDER

Before the Court is Defendants Renown Health, Renown Regional Medical Center, and Renown South Meadows Medical Center's (collectively "Renown") Motion to Dismiss. Doc. #28.[1] Relator Cecilia Guardiola ("Guardiola") filed an Opposition (Doc. #42), to which Renown replied (Doc. #43).

I. Factual and Procedural History

Renown Health, a Nevada nonprofit organization, is the umbrella corporation under which related entities, including Renown Regional Medical Center ("Regional") and Renown South Meadows Medical Center ("South Meadows"), provide acute health care services. Doc. #17, ¶11. Guardiola is a registered nurse and compliance professional who, on June 1, 2009, was hired by Renown as Director of Clinical Documentation. *Id.*, ¶9. Guardiola's role was to improve medical documentation in order to support improved billing. *Id.* Guardiola was

[1] Refers to the Court's docket number.

eventually promoted to Director of Clinical Compliance, but after her efforts at improving the billing system were allegedly stifled by Renown, she resigned on January 15, 2012. *Id.*

On January 10, 2014, Guardiola filed an Amended *qui tam* Complaint against Renown to recover damages resulting from Renown's knowing efforts to defraud government-funded health insurance programs, specifically Medicare.[2] *Id.*, pp. 1-2. Guardiola alleges that, from July 2007 through March 2011, Renown knowingly submitted or, in reckless disregard of the truth, allowed to be submitted, short-stay inpatient claims ("zero-day stays" and "one-day stays") that should have been billed as outpatient claims. *Id.*, ¶¶29, 72-77. Guardiola further alleges that these improperly billed claims were caused by (1) inadequate clinical documentation to support inpatient claims, (2) antiquated computer systems that generated false claims, (3) internal processes designed to improperly assign inpatient admission status, and (4) a lack of review to ensure appropriate inpatient status assignments. *Id.*, ¶30. Guardiola became aware of the alleged deficiencies in the Renown billing system during the fourth quarter of 2009. *Id.*, ¶33. Allegedly Renown did nothing to correct and/or prevent these problems. *Id.* Guardiola claims that she brought these problems to the attention of Renown management personnel and none of them acted to correct and/or prevent the Medicare claims from being improperly labeled and billed. *Id.*, ¶¶49-71. Moreover, Guardiola alleges that Renown management encouraged, directed, and facilitated the continued fraudulent activity against Medicare. *Id.*, ¶¶78-89. Finally, Guardiola alleges that Renown management engaged in the aforementioned fraudulent activity in order to obtain higher payments from Medicare. *Id.*

II. Legal Standard

Renown seeks dismissal of Guardiola's Amended Complaint pursuant to Federal Rule of Civil Procedure 12(b)(6) for failure to state a claim upon which relief can be granted. To survive

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[2] Guardiola filed her initial Complaint on June 1, 2012. Doc. #1. A *qui tam* claim pursuant to 31 U.S.C. § 3730(b)(1) allows an individual to bring a civil action in violation of 31 U.S.C. § 3729 (the "False Claims Act" or the "FCA") on behalf of and in the name of the United States Government. In *qui tam* actions, the individual bringing the claim on behalf of the Government is considered the "Relator."

a motion to dismiss for failure to state a claim, a complaint must satisfy the Federal Rule of Civil Procedure 8(a)(2) notice pleading standard. *See Mendiondo v. Centinela Hosp. Med. Ctr.*, 521 F.3d 1097, 1103 (9th Cir. 2008). That is, a complaint must contain "a short and plain statement of the claim showing that the pleader is entitled to relief." Fed. R. Civ. P. 8(a)(2). The Rule 8(a)(2) pleading standard does not require detailed factual allegations; however, a pleading that offers "'labels and conclusions' or 'a formulaic recitation of the elements of a cause of action'" will not suffice. *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 555 (2007)).

Furthermore, Rule 8(a)(2) requires a complaint to "contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Id.* (quoting *Twombly*, 550 U.S. at 570). A claim has facial plausibility when the pleaded factual content allows the court to draw the reasonable inference, based on the court's judicial experience and common sense, that the defendant is liable for the misconduct alleged. *See id.* at 678-79. "The plausibility standard is not akin to a probability requirement, but it asks for more than a sheer possibility that a defendant has acted unlawfully. Where a complaint pleads facts that are merely consistent with a defendant's liability, it stops short of the line between possibility and plausibility of entitlement to relief." *Id.* at 678 (internal quotation marks and citation omitted).

In reviewing a motion to dismiss, the court accepts the facts alleged in the complaint as true. *Id.* The "factual allegations that are taken as true must plausibly suggest an entitlement to relief, such that it is not unfair to require the opposing party to be subjected to the expense of discovery and continued litigation." *Starr v. Baca*, 652 F.3d 1202, 1216 (9th Cir. 2011). Moreover, "bare assertions . . . amount[ing] to nothing more than a formulaic recitation of the elements of a . . . claim . . . are not entitled to an assumption of truth." *Moss v. U.S. Secret Serv.*, 572 F.3d 962, 969 (9th Cir. 2009) (citing *Iqbal*, 556 U.S. at 681) (brackets in original) (internal quotation marks omitted). The court discounts these allegations because "they do nothing more than state a legal conclusion—even if that conclusion is cast in the form of a factual allegation." *Id.* (citing *Iqbal*, 556 U.S. at 681). "In sum, for a complaint to survive a motion to dismiss, the non-conclusory 'factual content,' and reasonable inferences from that content, must be plausibly

suggestive of a claim entitling the plaintiff to relief." *Id*.

Moreover, because FCA claims are grounded in fraud, they must meet the heightened pleading standard of Federal Rule of Civil Procedure 9(b). *See Cafasso v. Gen. Dynamics C4 Sys., Inc.*, 637 F.3d 1047, 1054 (9th Cir. 2011). Rule 9 provides that "[i]n alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake." Fed. R. Civ. P. 9(b). An allegation of fraud must be "specific enough to give defendants notice of the particular misconduct which is alleged to constitute the fraud so that they can defend against the charge and not just deny that they have done anything wrong." *Semegen v. Weidner*, 780 F.2d 727, 731 (9th Cir. 1985). Averments of fraud must be accompanied by "'the who, what, when, where, and how of the misconduct charged,' as well as 'what is false or misleading about [the purportedly fraudulent] statement, and why it is false.'" *Cafasso*, 637 F.3d at 1055 (quoting *Ebeid ex rel. United States v. Lungwitz*, 616 F.3d 993, 998 (9th Cir. 2010)).

Nevertheless, "this is a pleading requirement, not an evidentiary burden. Thus, although the focus of the FCA is on false claims, plaintiff need not identify representative examples of false claims at the pleading stage." *United States ex rel. Huey v. Summit Healthcare Ass'n, Inc.*, 2011 WL 814898, at *4 (D. Ariz. March 3, 2011) (citing *Ebeib*, 616 F.3d at 998-99). "Instead, 'it is sufficient to allege particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted.'" *Id*.

III. Discussion

Here, Guardiola alleges that Renown violated subparagraphs (A), (B), and (G) when it knowingly submitted inpatient claims to Medicare for payment that should have been billed on an outpatient or outpatient observation basis. *See* Doc. #17, ¶¶ 90-108. As amended, the FCA extends civil liability to any person who:

> (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; . . . or (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government, is liable to the United States Government . . . .

31 U.S.C. §§ 3729(a)(1)(A), 3729(a)(1)(B), 3729(a)(1)(G). An FCA suit "require[s] a false

claim," and "attaches liability, not to the underlying fraudulent activity or to the government's wrongful payment, but to the claim for payment." *Cafasso*, 637 F.3d at 1055 (citations and internal quotation marks omitted). "The plain language of the FCA contemplates liability not only for fraudulently causing the Government to pay a claim, but also for causing the Government to *approve* a claim." *United States v. Eghbal*, 548 F.3d 1281, 1283 (9th Cir. 2008) (emphasis in original) (citing 31 U.S.C. § 3729(a)(1)). Moreover, "FCA liability attaches to a false statement that has a 'material effect' on the Government's eventual decision to pay a claim." *Eghbal*, 548 F.3d at 1283 (quoting *Allison Engine Co., Inc. v. United States ex rel. Sanders*, 553 U.S. 662, 671-73 (2008)).

"[T]he FCA recognizes two types of actionable claims—factually false claims and legally false ['false certification'] claims." *United States ex rel. Conner v. Salina Reg'l Health Ctr., Inc.*, 543 F.3d 1211, 1217 (10th Cir. 2008); *see also United States v. Corinthian Colleges*, 655 F.3d 984, 992 (9th Cir. 2011) (citing *United States ex rel. Hendow v. University of Phoenix*, 461 F.3d 1166, 1171 (9th Cir. 2006)). Factually false claims arise when "the government payee has submitted 'an incorrect description of goods or services provided or a request for reimbursement for goods or services never provided.'" *Id.* (citing *Mikes v. Straus*, 274 F.3d 687, 697 (2d Cir. 2001). "Factual falsity" simply means a provider may not bill for something it does not provide. On the other hand, "in a claim based on a [false certification], the relator must demonstrate that the defendant has 'certifie[d] compliance with a statute or regulation as a *condition* to government payment,' yet knowingly failed to comply with such statute or regulation." *Id.* (emphasis in original).

Although the FCA is targeted at fraud, its "knowingly" scienter requirement does not require "proof of specific intent to defraud." 31 U.S.C. § 3729(b)(1)(B). A person acts "knowingly" with respect to information if he has actual knowledge of the information, or he acts in deliberate ignorance of, or in reckless disregard of, the truth or falsity of the information. 31 U.S.C. § 3729(b)(1)(A). Moreover, "the phrase 'known to be false' in that sentence does not mean 'scientifically untrue'; it means 'a lie.' The [FCA] is concerned with ferreting out 'wrongdoing,' not scientific errors." *Wang v. FMC Corp.*, 975 F.2d 1412, 1421 (9th Cir. 1992)

(citation omitted).

Here, the Court finds that Guardiola adequately alleges that Renown engaged in a fraudulent course of conduct whereby it knowingly submitted claims to Medicare for reimbursement for patients who were improperly characterized as inpatient. Specifically, Guardiola alleges that Renown submitted inpatient claims for patients who should not have been characterized as such under the applicable Medicare regulations. Guardiola further alleges that Renown submitted inpatient claims for patients who were not actually characterized as such by hospital physicians or staff. In essence, Guardiola alleges that Renown submitted these inpatient claims with "an incorrect description of the goods or services provided" or "requested reimbursement for goods or services never provided." *See Conner*, 543 F.3d at 1217. As such, Guardiola proceeds on the theory that Renown's claims were "factually false," as opposed to "legally false."[3]

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[3] Although Guardiola does not specify in her Amended Complaint whether she is proceeding on a theory of factual falsity, false certification, or both, the Court finds that her allegations speak for themselves. The allegedly fraudulent scheme rests on an incorrect description of the goods or services provided as well as a request for reimbursement for goods or services never provided. As such, the Court finds that Guardiola's claims are appropriately characterized as factually false claims under the FCA. Additionally, in her Opposition to Renown's Motion to Dismiss, Guardiola clarifies that this "is substantively a case of factually false submissions" as her claim is that Renown "falsely billed the Medicare program for inappropriate inpatient claims." Doc. #42, pp. 11, 15-16. Accordingly, the Court declines to address Renown's argument that Guardiola's Amended Complaint should be dismissed for failure to state a claim for legally false certification.

Moreover, because Guardiola did not address Renown's argument as to the sufficiency of any false certification claims, the Court shall not entertain this as a basis on which Guardiola's Amended Complaint may proceed. *See id.*, p. 16 n.8 ("Relator declines to engage the Defendants as to whether the identified conduct can independently serve as the basis for a [legally false] FCA violation."). The Court rejects Guardiola' attempt to "reserve the right to demonstrate that these so-called 'conditions of participation'—such as being truthful when submitting claims—can serve a basis for liability." *See id.* Should Guardiola wish to assert claims for legally false certification under the FCA at a later time, she must file an appropriate motion requesting leave to amend.

A. Medicare Guidelines

The Medicare regulations governing the determination of inpatient status form the basis for Guardiola's allegation that Renown submitted factually false claims. Guardiola's references thereto do not transform her factually false claim into a legally false claim. In this regard, the Court finds *United States v. R&F Properties of Lake County, Inc.*, 433 F.3d 1349 (11th Cir. 2005), instructive. In reversing the district court on summary judgment, the Eleventh Circuit found that the relator should be permitted to present evidence to a fact-finder supporting her allegations that Medicare claims submitted for certain services were not, in fact, rendered in compliance with the applicable Medicare regulation, and, therefore, were false. *Id.* at 1356. The court proceeded on the theory that Medicare claims may be false if they claim reimbursement for services or costs that were not rendered as claimed. *Id.* Similarly here, Guardiola alleges that Renown submitted claims for certain services (i.e., inpatient services) that were not, in fact, rendered in compliance with the applicable Medicare regulations.

Medicare is a federally-funded health insurance program administered by the Centers for Medicare & Medicaid Services ("CMS") through a framework of statutes, regulations, and guidelines governing billing and payment services under Medicare. Doc. #17, ¶15. According to the Medicare Claims Processing Manual, "[participant hospitals] may bill only for services provided. If the provider billing system initiates billing based on services ordered, the provider must confirm that the service has been provided before either the carrier or intermediary (FI)." *See Medicare Claims Processing Manual*, Chapter 3, § 10.

Medicare claims for hospital patients are labeled within at least three distinct categories: (1) inpatient, (2) outpatient observation, and (3) outpatient. Doc. #17, ¶¶16-19. Medicare defines an inpatient as "a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services." *Medicare Benefit Policy Manual*, Chapter 1, § 10. "Inpatient hospital services" are defined in Title XVIII of the Social Security Act and in the regulations (42 C.F.R. § 409.10). According to the Medicare Benefit Policy Manual:

> [t]he physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark, i.e., they

> should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting.

Medicare Benefit Policy Manual, Chapter 1, § 10. Moreover, "[a]dmissions of particular patients are not covered or noncovered solely on the basis of the length of time the patient actually spends in the hospital." *Id.* For example:

> [w]hen patients with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for only a few hours (less than 24), they are considered outpatients for coverage purposes regardless of: the hour they came to the hospital, whether they used a bed, and whether they remained in the hospital past midnight.

Id.

In contrast, "[a] hospital outpatient is a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and receives services (rather than supplies alone) from the hospital[.]" *Id.*, Chapter 6, §20.2. Outpatient observation care is defined as:

> a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.

Id., Chapter 6, § 20.6.A. "When a physician orders that a patient receive observation care, the patient's status is that of an outpatient." *Id.*, Chapter 6, § 20.6.B. In her Amended Complaint, Guardiola explains that the coding system for classifying and reporting outpatient procedures to Medicare is different than that for inpatient procedures. Doc. #17, ¶¶20-23.

B. Guardiola's Specific Allegations

Guardiola sets forth a list of 579 inpatient claims for "zero-day stays," in which the patient was admitted to and discharged from the hospital on the same calendar day. *Id.*, ¶72. Additionally, Guardiola specifically sets forth a list of 68 inpatient claims for "one-day stays," the vast majority of which she claims were for patients who were discharged within 24 hours of

admission to the hospital. *Id.*, ¶¶74, 76. Each of those claims, Guardiola alleges, was for an elective outpatient surgical procedure. *Id.*, ¶75. Moreover, none of the procedures involved are listed on the Medicare Inpatient Only List. *Id.*, ¶76. Guardiola further alleges that many of the patient files which accompany these short-stay claims are missing doctor's admission orders indicating that inpatient status is necessary or any other medical documentation that would justify inpatient admission. *Id.* In addition, Guardiola alleges that patient #34 on the "one-day stay" list was placed, by physician order, in outpatient observation status and then later billed as inpatient. *Id.*, ¶77. In each of these cases, Guardiola alleges that Medicare paid an inflated amount for the patient's care as a result of Renown's fraudulent inpatient assignments. *Id.*, ¶¶76, 77.

Guardiola further sets forth four circumstances that, if accepted as true, plausibly suggest the existence of a scheme whereby Renown knowingly submitted claims for payment to Medicare that falsely represented that the patients were inpatient and, thus, received inpatient services. *Id.*, ¶30; *See also United States ex rel. Lemmon v. Envirocare of Utah, Inc.*, 614 F.3d 1163, 1172 (10th Cir. 2010) ("claims under the FCA need only show the specifics of a fraudulent scheme and provide an adequate basis for a reasonable inference that false claims were submitted as part of that scheme") (citing *United States ex rel. Duxbury v. Ortho Biotech Prods.*, 579 F.3d 13, 29 (1st Cir. 2009); *United States ex rel. Lusby v. Rolls-Royce Corp.*, 570 F.3d 849, 854-55 (7th Cir. 2009); *United States ex rel. Grubbs v. Kanneganti*, 565 F.3d 180, 190 (5th Cir. 2009)).

First, Guardiola alleges that a high percentage of the patient files at Regional and South Meadows were missing physician orders for inpatient status and/or contained inadequate documentation to support a determination of the same. Doc. #17, ¶31. Guardiola further alleges that Renown deliberately failed and refused to maintain proper documentation in order to facilitate improper billing. *Id.*, ¶30.

Second, Guardiola alleges that Renown maintained an antiquated patient management computer system that generated false claims. *Id.*, ¶32. According to Guardiola, once a patient is initially and improperly registered as an inpatient, that status could not be changed until the patient was discharged. *Id.* As such, even if a patient is later treated on an outpatient or outpatient observation basis and properly coded as such, the computer system overrides the

accurate coding with billing codes according to the original patient status. *Id.* Guardiola alleges that she first detected the problem in the fourth quarter of 2009 and that Renown administrators were well aware of the problem, but did nothing to remedy it. *Id.*, ¶33.

Third, Guardiola alleges that Renown maintained internal processes designed to assign improper patient statuses. *Id.*, ¶36. When a patient is scheduled for an elective surgical procedure, his or her doctor's office calls the hospital scheduler to set up an appointment. *Id.*, ¶37. Once the surgical appointment is scheduled, hospital administrative personnel assign a patient account number that is unique for that encounter. *Id.*, ¶38. Account numbers preceded by a '1' designate inpatient status and account numbers preceded by a '2' designate outpatient status. *Id.* Unless the doctor's office specifically indicates at that time that the patient should be listed as a "same day surgery" or outpatient status, Renown automatically assigns an inpatient account number. *Id.*, ¶39. Three to seven days before the scheduled procedure, the patient's physician will issue a preoperative order that designates the patient's admission status. *Id.*, ¶40. Renown does not use this information to change or correct the status already associated with the patient account number. *Id.* Accordingly, the physician's designation as to the patient's status and patient's actual treatment is irrelevant for purposes of billing because the patient account number has already been determined and the computer system will not allow changes to the original patient status. *Id.*, ¶39.

Guardiola further maintains that a patient's inpatient or outpatient status cannot be altered once the patient has been discharged and his or her claim goes to billing. Even where Renown's billing coder correctly assigns outpatient billing codes for a patient who has received outpatient services, the computer system will detect any inconsistencies between the patient's numeric inpatient status and his or her assigned outpatient billing codes and automatically generate an inpatient billing code. *Id.*, ¶¶41, 42. In essence, the computer system ignores the billing coder's work and appropriate outpatient status and automatically bills the claim as if the inpatient status was correct. *Id.*, ¶43. Guardiola alleges that Renown was aware of these problems, but was unwilling to correct them by providing staff to perform an appropriate pre-admission review as she suggested. *Id.*, ¶44.

Additionally, Guardiola alleges that Renown management actually directed that certain types of procedures always be billed as inpatient claims. *Id.*, ¶80. For example, Guardiola discovered that two physicians were performing outpatient procedures on an exclusively inpatient basis even though they were not on Medicare's Inpatient Only List and no other circumstances justified their performance as inpatient procedures.[4] *Id.*, ¶¶65-68. Additionally, Guardiola discovered that Renown, in conjunction with another physician's management team, mandated that all Da Vinci hysterectomy procedures be performed on an inpatient basis, even though such procedures are not on the Medicare Inpatient Only List. *Id.*, ¶¶65, 82. Evidently, CEO Greg Boyer and COO Kris Gaw admitted that these directives existed in the past, but stated that a new procedure needed to be developed. *Id.*, ¶81. However, Renown leadership did not ultimately implement corrections to address the alleged billing fraud. *Id.*, ¶87.

Fourth, Guardiola alleges that the absence of any sort of post-procedure review process to ensure that patients are assigned the correct status further perpetuates a scheme whereby Renown knowingly submits false claims for inpatient services to Medicare. *Id.*, ¶¶45, 46.

C. Renown's Knowledge

Considering the aforementioned allegations, the Court finds that Guardiola has sufficiently alleged that Renown had actual knowledge of the fraud, or, at a minimum, acted in deliberate ignorance of, or in reckless disregard of, the falsity of the inpatient claims. Guardiola specifically alleges that in 2009 she approached her then-boss, Renown Health CFO Mark Johnson, with her concerns that Renown was systematically billing Medicare for one-day inpatient stays for what should have been outpatient claims. *Id.*, ¶49. Johnson approved of

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[4] Medicare's "Inpatient Only List" identifies certain surgical procedures that may be billed exclusively on an inpatient basis. However, there is no indication that this is an exhaustive list of procedures for which Renown may properly bill as inpatient claims. While the Court is not required or inclined to accept Guardiola's legal conclusion that the Inpatient Only List "creates a rebuttable presumption that any procedure not on the list must be performed on an outpatient basis[,]" the Court must accept as true Guardiola's factual assertion that many of the improperly billed inpatient claims were for procedures not listed on the Inpatient Only List and for which no other criteria justified inpatient admission. *Id.*, ¶25.

Guardiola's proposed formation of a Patient Status Committee ("PSC") to explore the scope of the problem and recommend and implement corrections. *Id.* After Johnson resigned, his successor, Dawn Ahner, agreed to proceed with the previously approved PSC proposal. *Id.*, ¶50. One of the PSC's first initiates was to address the findings of a recent audit that revealed that Renown had a significant "one-day stay" problem based on inaccurate clinical documentation and that Renown was submitting inpatient claims for patients whose one-day hospital stays should have been billed on an outpatient basis. *Id.*, ¶52. Despite some efforts to remedy the "short-stay" billing problems, Renown was ultimately aware that the new safeguards were inadequate and further refused to undertake any sort of post-procedure review to ensure that a patient's status was correct. *Id.*, ¶¶53-55. Moreover, Guardiola asserts that her efforts to educate physicians and staff at Renown about appropriate admission status standards were largely ignored or challenged, by both Renown and the physicians who worked there. *Id.*, ¶¶57-68. Again in 2011, during meetings in which Guardiola participated, Renown management acknowledged the billing problems. *Id.*, ¶¶80, 81. Nevertheless, Renown leadership failed to undertake appropriate corrective measures. *Id.*, ¶87.

Guardiola also alleges that Renown was aware of the Medicare rules pertaining to billing for inpatient/outpatient services. *Id.*, ¶89. Specifically, Renown knew that when a patient does not meet inpatient criteria and is admitted for a one-day stay, that payment may not be sought for an inpatient claim and must be submitted as an outpatient claim. *Id.*, ¶88. Additionally, Guardiola alleges that Renown knew that if a patient is erroneously billed as an inpatient claim, a corrected claim form should be submitted to correct the billing. *Id.*

D. Pleading Specificity Under Rule 8(a)(a) and Rule 9(b)

Considering the length of time for which the patients were admitted to the hospital, the lack of documentation supporting an inpatient determination, the type of procedures that were performed (i.e., outpatient procedures), the fact that none of the procedures were listed on Medicare's Inpatient Only List, the faulty computer billing systems, Renown's admittedly problematic directives regarding characterization of inpatient procedures, the absence of any post-discharge review process, and Renown's awareness of the inpatient billing issues, the Court

finds that Guardiola has plausibly alleged that Renown knowingly billed Medicare for inpatient claims that should have been billed as outpatient claims. The Court also finds that Guardiola has satisfied Rule 9(b)'s heightened pleading standard. Guardiola sets forth the details of the alleged scheme and its falsehoods, as well as the manner in which the allegedly false claims were submitted to Medicare for payment. Moreover, without pre-discovery access to patient specifics, it would be nearly impossible for Guardiola to access the medical records of both Renown facilities and specify every instance where Medicare was improperly billed for inpatient claims. *See U.S. Ex. Rel. Lee v. SmithKline Beecham, Inc.*, 245 F.3d 1048, 1052 (9th Cir. 2001) (Rule 9(b)'s pleading standard may be relaxed to permit discovery in cases where the evidence of fraud is within a defendant's exclusive possession); *see also Ebeid*, 616 F.3d at 999 (while relator "is not required to allege all facts supporting each and every instance of [fraudulent] billing . . . [,] Rule 9(b) still requires [relator] to plead the fraud with some level of specificity") (internal quotation marks and citations omitted). Certainly, Guardiola's Amended Complaint is specific enough to give Renown notice of the particular misconduct which is alleged to constitute the fraud so that they can defend against the charge and not just deny that they have done anything wrong.

Renown misrepresents Guardiola's allegations when it states that "[t]he response brief admits the amended complaint 'does *not* allege that these patients did not *require or receive* the procedures or treatments' for which Medicare was billed." Doc. #43, p. 3 (quoting Doc. #43, p. 14 n.6) (underline added). Contrary to Renown's assertion, Guardiola merely admits that the Amended Complaint "does not allege that the patients did not require or receive the procedures or treatments rendered to them by [Renown]." *Id.* at 14 n.6 (underline added). In this regard, it is clear that Guardiola does not allege that Renown actually administered procedures or treatments that were unnecessary or unreasonable. This lawsuit has nothing to do with whether the procedures or treatments Renown actually administered were necessary and reasonable. Rather, the crux of the Amended Complaint is that Medicare claims were improperly billed as inpatient when they should have been billed as outpatient or observation status based on the procedures or treatments provided by Renown. In other words, Guardiola alleges that Renown

submitted claims for services that were not actually provided and submitted claims with an incorrect description of the services provided.

Renown further distorts the issue when it claims that in order "to state a claim for factual falsity, the amended complaint must plausibly allege that the defendants knowingly submitted inpatient claims for patients who were not actually admitted as inpatients." *Id.* at 3. However, the issue is not whether Renown submitted inpatient claims for patients who were *admitted* as an inpatient. Rather, the issue is whether Renown submitted inpatient claims for patients who were not properly admitted and/or characterized by Renown as inpatient based on the services provided.

Finally, the Court rejects Renown's assertion that Guardiola's allegations as to "one-day stay" patient #34 do not plausibly suggest wrongdoing with respect to that single claim, but merely suggest a mistake. Whether the facts will ultimately support Guardiola's claims or whether they will show only an innocent mistake or mere negligence on the part of Renown are issues that cannot be resolved on a motion to dismiss. Accordingly, the Court rejects Renown's argument in this regard.

In sum, the Court finds that Guardiola has adequately alleged a plausible claim for relief against Renown under the FCA.

IT IS THEREFORE ORDERED that Renown's Motion to Dismiss (Doc. #28) is DENIED.

IT IS SO ORDERED.

DATED this 19th day of August, 2014.

LARRY R. HICKS
UNITED STATES DISTRICT JUDGE